		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035477

Facility Name: Exceptional Care & Training Center

Address: 2601 Woodlawn Road (Number) Sterling (City) 61081 (Zip Code)

County: Whiteside

Telephone Number: (815) 626-8520 **Fax #** (815) 626-8075

IDPA ID Number: 31-1262572

Date of Initial License for Current Owners: 08/15/89

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501 (c)(3)	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: James R. Johnson **Telephone Number:** (859) 255-0075

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/03 to 6/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) James R. Johnson
(Title) V.P. of Finance - Medical Rehabilitation Centers, Inc.

Paid Preparer

(Signed) See Compilation Report (Date)
(Print Name and Title) Robert A. Thomas, Partner
(Firm Name & Address) Thomas Healthcare Consulting, P.C., 11988 Fishers Crossing Dr., Suite 200, Fishers, IN 46038
(Telephone) (317) 577-0101 Fax # (317) 577-3389

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	79	Skilled Pediatric (SNF/PED)	79	28,914	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	79	TOTALS	79	28,914	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	28,714	0	0	28,714	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,714			28,714	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.31%

D. How many bed-hold days during this year were paid by Public Aid?
125 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/15/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/15/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/04 Fiscal Year: 6/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	169,240	17,700	4,143	191,083	150	191,233		191,233			1
2	Food Purchase		111,651		111,651		111,651		111,651			2
3	Housekeeping	94,781	12,883		107,664	400	108,064		108,064			3
4	Laundry	127,996	17,501		145,497	150	145,647		145,647			4
5	Heat and Other Utilities			103,099	103,099		103,099		103,099			5
6	Maintenance	64,426	8,655	37,865	110,946	200	111,146		111,146			6
7	Other (specify):*											7
8	**TOTAL General Services**	456,443	168,390	145,107	769,940	900	770,840		770,840			8
	B. Health Care and Programs											
9	Medical Director			12,600	12,600		12,600		12,600			9
10	Nursing and Medical Records	1,462,805	60,636	8,013	1,531,454	289	1,531,743		1,531,743			10
10a	Therapy	31,277		10,988	42,265		42,265		42,265			10a
11	Activities	175,244	2,079		177,323	100	177,423		177,423			11
12	Social Services											12
13	Nurse Aide Training											13
14	Program Transportation		2,841	1,258	4,099		4,099		4,099			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,669,326	65,556	32,859	1,767,741	389	1,768,130		1,768,130			16
	C. General Administration											
17	Administrative	72,905		131,871	204,776	(130,966)	73,810	(905)	72,905			17
18	Directors Fees					7,244	7,244		7,244			18
19	Professional Services			369,555	369,555	40,654	410,209		410,209			19
20	Dues, Fees, Subscriptions & Promotions			24,995	24,995	148	25,143	(461)	24,682			20
21	Clerical & General Office Expenses	48,907	13,468	12,895	75,270	29,082	104,352	(706)	103,646			21
22	Employee Benefits & Payroll Taxes			549,604	549,604	3,016	552,620		552,620			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,262	3,262	2,016	5,278		5,278			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			39,796	39,796		39,796		39,796			26
27	Other (specify):* **Bad Debt**			200	200		200	(200)				27
28	**TOTAL General Administration**	121,812	13,468	1,132,178	1,267,458	(48,806)	1,218,652	(2,272)	1,216,380			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,247,581	247,414	1,310,144	3,805,139	(47,517)	3,757,622	(2,272)	3,755,350			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Exceptional Care & Training Center #0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			132,113	132,113	21	132,134		132,134			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			349,864	349,864	47,739	397,603	(24,082)	373,521			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			243	243	(243)						35
36	Other (specify):* **Amortization**			29,581	29,581		29,581	(20,759)	8,822			36
37	**TOTAL Ownership**			511,801	511,801	47,517	559,318	(44,841)	514,477			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			273,580	273,580		273,580		273,580			42
43	Other (specify):* **Day Training**	716,214	15,318	77,412	808,944		808,944		808,944			43
44	**TOTAL Special Cost Centers**	716,214	15,318	350,992	1,082,524		1,082,524		1,082,524			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,963,795	262,732	2,172,937	5,399,464		5,399,464	(47,113)	5,352,351			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(24,082)	32		10
11	Discounts, Allowances, Rebates & Refunds	(706)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(461)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(200)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Goodwill	(20,759)	36		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (46,208)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(905)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (905)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (47,113)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39		X		SNF/PED		39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Exceptional Care & Training Center

ID# 0035477

Report Period Beginning: 7/1/03

Ending: 6/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Goodwill	$ (20,759)	36	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(20,759)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Exceptional Care & Training Center # 0035477 **Report Period Beginning:** 7/1/03 **Ending:** 6/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(905)	0	0	0	0	0	0	0	0	0	(905)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(461)	0	0	0	0	0	0	0	0	0	0	(461)	20
21	Clerical & General Office Expenses	(706)	0	0	0	0	0	0	0	0	0	0	(706)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(200)	0	0	0	0	0	0	0	0	0	0	(200)	27
28	**TOTAL General Administration**	(1,367)	(905)	0	0	0	0	0	0	0	0	0	(2,272)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,367)	(905)	0	0	0	0	0	0	0	0	0	(2,272)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Exceptional Care & Training Center** **#** **0035477** **Report Period Beginning:** **7/1/03** **Ending:** **6/30/04**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(24,082)	0	0	0	0	0	0	0	0	0	0	(24,082)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(20,759)	0	0	0	0	0	0	0	0	0	0	(20,759)	36
37	**TOTAL Ownership**	(44,841)	0	0	0	0	0	0	0	0	0	0	(44,841)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(46,208)	(905)	0	0	0	0	0	0	0	0	0	(47,113)	45

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Swann Special Care Center	Champaign			
		Walter Lawson Children's Home	Loves Park			
		Vernon Manor Children's Home	Wabash, Indiana			
		Richland Bean-Blossom HCC	Ellettsville, Indiana			
		Hanover Nursing Center	Hanover, Indiana			
		Clay County Nursing Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Corporate Expense	$ 131,871	Hoosier Care, Inc.	100.00%	$ 130,966	$ (905)	1
2	V								2
3	V				Note: See schedule VIII of allocation of cost per column 7.				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 131,871			$ 130,966	$ * (905)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Bruce Hutson, M.D.	Director	Board Meetings	0.00	8,069			Director Fees	$ 1,448	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	8,068			Director Fees	1,449	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	8,068			Director Fees	1,449	18.8	3
4	John Foos	Director	Board Meetings	0.00	8,067			Director Fees	1,449	18.8	4
5	Michael Conn	Director	Board Meetings	0.00	8,067			Director Fees	1,449	18.8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 7,244		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Hoosier Care, Inc.
Street Address: 535 West Second, Suite 105
City / State / Zip Code: Lexington, KY 40508
Phone Number: (859) 255-0075
Fax Number: (859) 281-5150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing / Medical Records	Revenue	40,575,961	8	$ 255	$ 0	6,177,447	$ 39	1
2	18	Director's Fees	Revenue	40,575,961	8	47,583	0	6,177,447	7,244	2
3	19	Professional Fees	Revenue	40,575,961	8	267,033	0	6,177,447	40,654	3
4	20	Fees,Subscription & Promotion	Revenue	40,575,961	8	969	0	6,177,447	148	4
5	21	Clerical & General Office Exp.	Revenue	40,575,961	8	189,427	0	6,177,447	28,839	5
6	22	Emp. Benefits & Payroll Tax	Revenue	40,575,961	8	30,076	0	6,177,447	4,579	6
7	24	Travel & Seminar	Revenue	40,575,961	8	11,189	0	6,177,447	1,703	7
8	30	Depreciation	Revenue	40,575,961	8	136	0	6,177,447	21	8
9	32	Interest Expense	Revenue	40,575,961	8	313,568	0	6,177,447	47,739	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 860,236	$		$ 130,966	25

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	City of Sterling Bonds-1999A		X	Purchase of Facility	Varies	7/8/99	$ 4,775,000	$ 4,585,000	6/1/2034	7.1250	$ 328,908	1
2	City of Sterling Bonds-1999B		X	Purchase of Facility	Varies	7/8/99	220,000	195,000	6/1/2019	10.5000	20,956	2
3												3
4												4
5												5
	Working Capital											
6	Home Office Allocation										47,739	6
7												7
8												8
9	TOTAL Facility Related						$ 4,995,000	$ 4,780,000			$ 397,603	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,995,000	$ 4,780,000			$ 397,603	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	None	8
	2000		9
	2001		10
	2002		11
	2003		12

Note: The facility became exempt from property taxes starting 1/1/96.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Exceptional Care & Training Center COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0035477

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,676 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SNF/PED	63,598	1989	$ 414,085	1
2					2
3	TOTALS	63,598		$ 414,085	3

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1989		$ 2,334,000	$ 58,000	10-35	$ 58,000	$	$ 1,169,166	4
5	15			1991	358,311	11,944	30	11,944		155,823	5
6											6
7											7
8											8
	Improvement Type**										
9	Boiler Repair			1990	964		10			964	9
10	Water Unit			1991	8,780		10			8,780	10
11	PA System			1991	696		10			696	11
12	Building Addition - Drywall			1991	403		10			403	12
13	Closet Curtain Track			1991	650		10			650	13
14	Door			1991	1,614		10			1,614	14
15	Boiler Repair			1992	6,180		10			6,180	15
16	Storm Windows			1992	907		10			907	16
17	Boiler Tubes			1992	7,147		10			7,147	17
18	Roof			1992	11,118		10			11,118	18
19	Kitchen Tile			1992	3,660		10			3,660	19
20	Heating & Cooling Unit			1992	7,757		10			7,757	20
21	Shed			1992	1,678		10			1,678	21
22	Gate & Fence Scars			1992	4,038		10			4,038	22
23	Landscaping			1992	2,398		10			2,398	23
24	Drain Replacement			1992	1,576		10			1,576	24
25	Black Top			1992	575		10			575	25
26	Light Fixtures			1992	3,743		10			3,743	26
27	Building Renovation			1993	139	5	30	5		59	27
28	Painting - Laundry			1993	351		10			351	28
29	Building Renovation			1993	7,106		10			7,106	29
30	Painting - Laundry			1993	262		10			262	30
31	Parking Lot			1993	1,800		10			1,800	31
32	Tile Installation			1993	1,020		10			1,020	32
33	Electrical Work			1993	3,255		10			3,255	33
34	Pipe Installation - Laundry			1993	156		10			156	34
35	Water Heater Renovation			1993	849		10			849	35
36	Final Payment - Laundry			1993	1,030		10			1,030	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Replace Relay in Panel	1993	$ 1,150	$ 19	10	$ 19	$	$ 1,150	37
38	Install New Sewer Lines	1993	4,105		10			4,105	38
39	New Water Main	1993	12,204	305	10	305		12,205	39
40	Replace Parts on Sump Pumps	1994	4,034	337	10	337		4,034	40
41	Installed Back Flow Preventor	1994	1,053	106	10	106		1,053	41
42	Large Toilet Support, Back Stop	1994	923	92	10	92		897	42
43	Deck	1994	814	81	10	81		783	43
44	New Roof	1994	29,435	2,943	10	2,943		27,713	44
45	Tile Floors in Tub Room	1994	4,405	441	10	441		4,153	45
46	Thermocouple on Boiler	1995	2,550	255	10	255		2,380	46
47	New Pump on Boiler System	1995	1,706	171	10	171		1,567	47
48	Air Conditioner Compressor	1995	1,668	167	10	167		1,517	48
49	Replace Fire Alarm	1995	3,743	374	10	374		3,397	49
50	Landscaping	1995	15,000	1,500	10	1,500		13,625	50
51	Counter Top	1995	527	53	10	53		503	51
52	New Door Frame Installed	1995	959	96	10	96		832	52
53	Rebuild Corner of Building	1996	2,000	200	10	200		1,650	53
54	Install Two Bell - Strobes	1996	888	89	10	89		734	54
55	Replace Relay & Timer on Generator	1996	1,325	132	10	132		1,056	55
56	Rebuild Commercial Water Softener	1996	1,880	188	10	188		1,645	56
57	Replace 3/4 H.P. Motor, Thermocoupler	1996	920	92	10	92		736	57
58	Replace Boiler Pumps and Bearing Assembly	1997	640	64	10	64		475	58
59	Install 3/4 H.P. Motor-Boiler	1997	725	72	10	72		522	59
60	Replace Circulating Pump, Bearings	1997	743	74	10	74		537	60
61	Twenty New Water Faucets	1997	2,296	230	10	230		1,648	61
62	Vinyl Floor Tile-Resident Room	1997	690	69	10	69		489	62
63	Reseal Parking Area	1997	2,845	285	10	285		2,019	63
64	Air Conditioning Condenser Unit	1997	1,650	165	10	165		1,128	64
65	Install Conduit	1997	913	91	10	91		614	65
66	Outlets & Wiring	1997	522	52	10	52		346	66
67	Kitchen Fire Suppression System	1998	767	77	10	77		494	67
68	Smoke Detectors	1998	621	62	10	62		398	68
69	Install Pipe & Wire	1998	995	99	10	99		627	69
70	TOTAL (lines 4 thru 69)		$ 2,876,859	$ 78,930		$ 78,930	$	$ 1,499,793	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,876,859	$ 78,930		$ 78,930	$	$ 1,499,793	1
2	Smoke Detectors	1998	1,644	165	10	165		1,046	2
3	Tank Replacement - PIPECO	1998	9,890	495	20	495		2,887	3
4	Generator and Transfer Switch Changeover	1998	2,746	275	10	275		1,604	4
5	Replace Tubes on Boiler, Galv. Pipes on Water Line	1998	1,690	169	10	169		958	5
6	Installed Boiler Control and Switch for Light	1998	709	71	10	71		408	6
7	Replace Faulty Smoke Detectors, Installed Batteries	1998	973	97	10	97		558	7
8	Installed Tile on Walls & in Staircase (New Addition)	1998	4,495	450	10	450		2,512	8
9	Two Hot Water Tanks Installed	1999	7,119	712	10	712		3,797	9
10	Installation Heavier Electric Service for Dishwasher	1999	1,651	165	10	165		880	10
11	Install New Cooling System Laundry / Kitchen	2000	4,650	233	20	233		1,048	11
12	Plaster & Drywall existing walls in Residents Rooms	2000	800	80	10	80		353	12
13	Install New Tile in Dinning Area & Two Classrooms	2000	4,770	318	15	318		1,352	13
14	Installed New Thermocuople on West Boiler	2000	353	35	10	35		149	14
15	Replace Thermocouple on West Boiler	2000	140	14	10	14		59	15
16	Replace Thermocouple on Inducer Fan	2000	215	21	10	21		89	16
17	Rebuilt two hopper foot valves / Installed Protectorelay	2000	1,430	143	10	143		608	17
18	Replace Coupler, Motor Mounts, Bearing assy, Impeller	2000	298	30	10	30		127	18
19	Labor to Install 120V Power to New Door Openers	2000	583	58	10	58		242	19
20	Replaced Bearing Assy on Hot Water Return Line	2000	518	52	10	52		217	20
21	Indicator Lamps & Voltage	2000	1,525	153	10	153		573	21
22	Replace Heat Exchanger	2001	962	96	10	96		336	22
23	Replace Heat Exchanger	2001	962	96	10	96		328	23
24	Replace Draft Inducer	2001	1,414	141	10	141		470	24
25	Replace Pipe	2001	530	53	10	53		177	25
26	Replace Clinical Sink	2001	2,304	154	15	154		500	26
27	Furnish & Install Awning	2001	2,771	185	15	185		601	27
28	Labor & Mat-Breaker Panel	2001	3,930	262	15	262		851	28
29	Install Thermo Coupler	2001	944	94	10	94		298	29
30	Install Electric For Dishwasher	2001	820	55	15	55		174	30
31	Reroof Facility and Garage	2001	13,960	558	25	558		1,767	31
32	Lusterboard Sign	2001	515	103	5	103		318	32
33	Excavation of New Parking	2001	12,415	621	20	621		1,966	33
34	TOTAL (lines 1 thru 33)		$ 2,964,585	$ 85,084		$ 85,084	$	$ 1,527,046	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,964,585	$ 85,084		$ 85,084	$	$ 1,527,046	1
2	Renovation Installment	2001	63,363	12,673	5	12,673		43,299	2
3	Concrete for Canapy & Add.	2001	2,592	519	5	519		1,730	3
4	Reconfigure Changing area	2001	3,393	679	5	679		1,867	4
5	Refund Electrical Panel	2001	(975)	(195)	5	(195)		(585)	5
6	Install Water Heater	2001	3,341	223	15	223		669	6
7	Conduit & Wiring for Door Holders	2001	1,982	132	15	132		396	7
8	Air Conditioning in Lobby-Motor Replacement	2001	349	35	10	35		102	8
9	East Tub Room Fan-Motor Replacement	2001	213	21	10	21		62	9
10	Dryer Vent Replacement	2001	319	32	10	32		93	10
11	Reconfigure Water Heater Room	2001	1,860	124	15	124		351	11
12	Walkway	2001	4,120	275	15	275		802	12
13	Hand Railing on Stairs to Upper Parking Lot	2002	2,130	142	15	142		319	13
14	Privacy Fence	2002	2,550	255	10	255		531	14
15	Install Temp Control Cartridge-Boiler	2002	537	36	15	36		90	15
16	Internet Set Up Wiring, Cable	2002	3,061	204	10	204		493	16
17	Motor Boiler	2002	763	76	10	76		177	17
18	Replace Hallow Metal Door	2002	1,665	111	15	111		231	18
19	Shutters	2002	820	82	10	82		171	19
20	Storm Window Project	2002	8,937	447	20	447		931	20
21	Replace Breaker, Ballasts	2002	555	111	5	111		277	21
22	Tennant Allowance to Offset Fix-up Costs	2002	(5,000)	(1,000)	5	(1,000)		(2,500)	22
23	New Motor on Boiler	2002	962	96	10	96		192	23
24	Installed Hospital Grade Outlet	2002	2,256	226	10	226		433	24
25	Wiring for New Time Clock	2003	634	63	10	63		79	25
26	Motor & Coupler / Circular	2003	835	83	10	83		104	26
27	Side Screens on DT Awning	2003	738	148	5	148		197	27
28	Anne's Landscaping	2004	590	10	10	10		10	28
29	Rounding		(1)	(4)		(4)		(5)	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,067,174	$ 100,688		$ 100,688	$	$ 1,577,562	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 106,857	$ 16,784	$ 16,784	$		$ 59,868	71
72	Current Year Purchases	28,002	2,022	2,022			2,022	72
73	Fully Depreciated Assets	392,905	1,065	1,065			392,905	73
74	Corporate Allocation		21	21				74
75	TOTALS	$ 527,764	$ 19,892	$ 19,892	$		$ 454,795	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transporation	1995 Ford Van	1998	$ 2,071	$ 172	$ 172	$		$ 2,071	76
77	Patient Transporation	1985 GMC Bus	2000	26,150	5,230	5,230			19,612	77
78	Patient Transporation	2002 Van	2002	30,758	6,152	6,152			12,816	78
79										79
80	TOTALS			$ 58,979	$ 11,554	$ 11,554	$		$ 34,499	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,068,002	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 132,134	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 132,134	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,066,856	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Multi-Purpose Room /	$ 324,896	92
93	Classroom to Resident Rooms		93
94			94
95		$ 324,896	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 **Report Period Beginning:** 7/1/03 **Ending:** 6/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,039	$	1
2	Cash-Patient Deposits	63,243		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (200)	492,097		3
4	Supply Inventory (priced at Cost)	11,950		4
5	Short-Term Investments			5
6	Prepaid Insurance	719		6
7	Other Prepaid Expenses	8,945		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Corporate	8,268,541		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,846,534	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	414,085		13
14	Buildings, at Historical Cost	3,067,174		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	586,743		16
17	Accumulated Depreciation (book methods)	(2,066,857)		17
18	Deferred Charges	264,654		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,911		21
22	Other Long-Term Assets (specify):	803,720		22
23	Other(specify): Goodwill	520,709		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,592,139	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,438,673	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (88,908)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	63,243		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	171,451		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,800		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	28,930		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 182,516	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,780,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,780,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,962,516	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,476,157	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,438,673	$	48

***(See instructions.)**

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,674,091	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,674,091	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	802,065	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 802,066	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,476,157	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,764,733	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,764,733	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	3,822	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,822	23
	D. Non-Operating Revenue		
24	Contributions	1,813	24
25	Interest and Other Investment Income***	24,082	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,895	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DMH Day Training	1,406,373	28
28a	Miscellaneous Income	706	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,407,079	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,201,529	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	769,940	31
32	Health Care	1,767,741	32
33	General Administration	1,267,458	33
	B. Capital Expense		
34	Ownership	511,801	34
	C. Ancillary Expense		
35	Special Cost Centers	808,944	35
36	Provider Participation Fee	273,580	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,399,464	40
41	**Income before Income Taxes (line 30 minus line 40)****	802,065	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 802,065	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,868	1,868	$ 50,235	$ 26.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,624	6,054	126,763	20.94	3
4	Licensed Practical Nurses	17,926	20,083	339,722	16.92	4
5	Nurse Aides & Orderlies	86,782	94,216	946,085	10.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,631	1,811	31,277	17.27	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,856	2,167	35,045	16.17	9
10	Activity Assistants	17,223	18,712	140,199	7.49	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,884	2,080	37,064	17.82	13
14	Head Cook	7,537	8,378	86,551	10.33	14
15	Cook Helpers/Assistants	4,842	5,255	45,625	8.68	15
16	Dishwashers					16
17	Maintenance Workers	3,942	4,490	64,426	14.35	17
18	Housekeepers	9,173	10,131	94,781	9.36	18
19	Laundry	11,683	12,890	127,996	9.93	19
20	Administrator	1,866	2,080	72,905	35.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,592	4,058	48,907	12.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Day Training	57,640	63,763	716,214	11.23	33
34	TOTAL (lines 1 - 33)	235,069	258,036	$ 2,963,795 *	$ 11.49	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	143	$ 4,143	1.3	35
36	Medical Director	96	12,600	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,650	10.3	39
40	Physical Therapy Consultant	37	1,897	10A.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	130	9,091	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental Fees	96	6,000	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	502	$ 35,381		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa Blaine	Administrator	0	$ 72,905
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,905

B. Administrative - Other

Description	Amount
Corporate Expense	$ 131,871
TOTAL (agree to Schedule V, line 17, col. 3)	$ 131,871
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Medical Rehabilitation		$
Centers, Inc.	Management Fees	363,600
Thomas Healthcare Consulting	Accounting Fees	3,750
Michael R. Albert	Legal Fees	2,205
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 369,555

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 133,630
Unemployment Compensation Insurance	11,077
FICA Taxes	222,327
Employee Health Insurance	164,093
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	16,914
Corporate Allocation	4,579
TOTAL (agree to Schedule V, line 22, col.8)	$ 552,620

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 79)	948
Illinois Health Care Assoc.	4,266
MES of Illinois	175
NAEIR	1,148
Corporate Allocation	148
Chamber of Commerce	461
Other Fees (See Attached)	17,997
Less: Public Relations Expense	( )
Non-allowable advertising	(461)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,682

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	1,952
Seminar Expense	1,623
Corporate Allocation	1,703
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,278

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/03 Ending: 6/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	None		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Exceptional Care & Training Center **#** 0035477 **Report Period Beginning:** 7/1/03 **Ending:** 6/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Schedule XIX, Section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,051** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **273,580**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **47,447**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Resnick, Fedder & Silverman** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.